California CARTS FY2020 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

California

2. Program type:

◉ Both Medicaid Expansion CHIP and Separate CHIP

◯ Medicaid Expansion CHIP only

◯ Separate CHIP only

3. CHIP program name(s):

All, California

Who should we contact if we have any questions about your report?

4. Contact name:

Anastasia Dodson

5. Job title:

Associate Director

6. Email:

anastasia.dodson@dhcs.ca.gov

7. Full mailing address:

Include city, state, and zip code.

PO BOX 997413, Sacramento, CA 95899-7143

8. Phone number:

916-440-7414

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

○   Yes

◉   No

2. Does your program charge premiums?

◉ Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

◉ Yes

○ No

2b. Indicate the range for premiums and corresponding FPL for one child.

Premiums for one child, tiered by FPL

FPL starts at

160 ➜

FPL ends at

266

Premium starts at

$ 13 ➜

Premium ends at

$ 39

○ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

○ **Yes**

3a. Indicate the range for premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at

160

FPL ends at

266

Premium starts at

$ 156

Premium ends at

$ 468

○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

$13 per child with maximum family contribution of $39. Families receive fourth month premium free, if three months paid in advance, use Electronic Funds Transfer or reoccurring credit card payments. This results in a 25% savings on the annual premiums.

5. Which delivery system(s) do you use?
Select all that apply.

☑ Managed Care

☐ Primary Care Case Management

☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

> All CHIP children are enrolled into a Medi-Cal managed care plan. Children enrolled into Presumptive Eligibility receive fee-for-service Medi-Cal until they have finalized their enrollment. Children eligible for CCS receive primary care through their managed care plan, while CCS services are delivered on a fee-for-service basis. In some counties, the plan is responsible for CCS services. CHIP eligible children receive specialty mental health services through a county mental health plan.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

○ Yes

◉ No

2. Does your program charge premiums?

◉ Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

◉ Yes

○ No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

Premiums for one child, tiered by FPL

FPL starts at

266

➔

FPL ends at

322

Premium starts at

$ 21

➔

Premium ends at

$ 63

○ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

⦿ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at

266

➜

FPL ends at

322

Premium starts at

$ 252

➜

Premium ends at

$ 756

○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

$21 per child with maximum family contribution of $63 (family is three or more children). Families receive fourth month premium free, if three months paid in advance. This results in a 25% savings on the annual premiums.

5. Which delivery system(s) do you use?
Select all that apply.

☑ Managed Care

☐ Primary Care Case Management

☑ Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

> All CHIP children are enrolled into a Medi-Cal managed care plan. Children enrolled into Presumptive Eligibility receive fee-for-service Medi-Cal until they have finalized their enrollment. Children eligible for CCS receive primary care through their managed care plan, while CCS services are delivered on a fee-for-service basis. In some counties, the Medi-Cal managed care plan is responsible for CCS services. CHIP eligible children receive specialty mental health services through a county mental health plan.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

○ Yes

◉ No

○ N/A

2. Have you made any changes to the eligibility redetermination process?

◉ Yes

○ No

○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

○ Yes

◉ No

○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

(●) Yes

( ) No

( ) N/A

5. Have you made any changes to the single streamlined application?

( ) Yes

(●) No

( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target
population.

( ) Yes

(●) No

( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

○ Yes

● No

○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

○ Yes

● No

○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

○ Yes

● No

○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

○ Yes

⦿ No

○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

○ Yes

⦿ No

○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

⦿ Yes

○ No

○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

○ Yes

◉ No

○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant women?

○ Yes

◉ No

○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

○ Yes

◉ No

○ N/A

16. Have you made changes to any other policy or program areas?

○   Yes

◉   No

○   N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

With the Public Health Emergency (PHE) due to the Coronovirus, DHCS waived premiums for this population when the family indicated financial hardship, using the authority in SPA 17-044. DHCS also issued two Medi-Cal Eligibility Division Information Letters (MEDILs) providing guidance to counties to allow flexibilities in processing negative actions, discontinuances, and renewals. This was done to ensure that no individual would fall out of coverage during the PHE. California also submitted SPA 20-0024 to implement temporary policies during the PHE including expanded eligibility policies and modalities surrounding Presumptive Eligibility, and any relevant cost-sharing.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

◉   Yes

○   No

○   N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year. Many changes listed in this section require a State Plan

Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

○   Yes

◉   No

○   N/A

2. Have you made any changes to the eligibility redetermination process?

◉   Yes

○   No

○   N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

○   Yes

◉   No

○   N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

⦿ Yes

◯ No

◯ N/A

5. Have you made any changes to the single streamlined application?

◯ Yes

⦿ No

◯ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target
population.

◯ Yes

⦿ No

◯ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

○ Yes

⦿ No

○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

○ Yes

⦿ No

○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

○ Yes

⦿ No

○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

○   Yes

◉   No

○   N/A

11. Have you made any changes to the enrollment process for health plan selection?

○   Yes

◉   No

○   N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

○   Yes

◉   No

○   N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

○ Yes (selected)

○ No

○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

○ Yes

○ No (selected)

○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

○ Yes

○ No (selected)

○ N/A

16. Have you made any changes to your Pregnant Women State Plan expansion?
For example: expanding eligibility or changing this population's benefit package.

- ◯ Yes

- ⦿ No

- ◯ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ◯ Yes

- ⦿ No

- ◯ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ◯ Yes

- ⦿ No

- ◯ N/A

19. Have you made changes to any other policy or program areas?

○ Yes

● No

○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

> With the PHE due to the Coronovirus, DHCS waived premiums for this population when the family indicated financial hardship, with the authority in SPA 17-0043. This SPA authority also allowed DHCS certain flexibilities in processing negative actions, discontinuances, and renewals. DHCS also issued two MEDILs providing guidance to counties to allow flexibilities for these population groups. California also submitted SPA 20-0024 to implement temporary policies during the PHE including expanded eligibility policies and modalities surrounding Presumptive Eligibility, and any relevant cost-sharing. BENEFITS: On 8/20/2019, CHIP SPA 18-0036 was approved, demonstrating compliance with the Medicaid Managed Care Final Rule. On 10/1/2019, DHCS successfully transitioned Population 1 (CCHIP) into the Medi-Cal Managed Care Delivery System, providing this population all the benefits provided to Medi-Cal subscribers/beneficiaries. DELIVERY SYSTEM: On 8/20/2019, CHIP SPA 18-0036 was approved, demonstrating compliance with the Medicaid Managed Care Final Rule. On 10/1/2019, DHCS successfully transitioned Population 1 (CCHIP) into the Medi-Cal Managed Care Delivery System, providing this population all the benefits provided to Medi-Cal subscribers/beneficiaries. OTHER - MANAGED CARE FINAL RULE: On 8/20/2019, CHIP SPA 18-0036 was approved, demonstrating compliance with the Medicaid Managed Care Final Rule.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

◉ Yes

○ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the

CARTS data below to update.

Program	Number of children enrolled in FFY 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	1,872,509	1,750,138	-6.535%
Separate CHIP	74,255	61,617	-17.02%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

FFY 2020 counts are not complete and may change with additional months of retroactive eligibility and paid claims data. The overall decrease correlates with California's lower unemployment and a growing economy prior to the public health emergency. The decrease seen in enrollment for MCHIP is slightly offset by increased enrollment beginning in April 2020, likely COVID-19 related due to the continuous coverage requirement under FFCRA. The decrease in SCHIP enrollment is primarily in the unborn child population. These counts will increase with additional months of data when we report final counts for FFY 2020. There has been a decline in this population over time believed to be due to California's lower unemployment and a growing economy prior to the public health emergency. Additionally, the unborn child enrollment are user counts based on Medi-Cal Fee-For-Service paid claims, the COVID-19 public health emergency has resulted in a decrease in utilization, further reducing counts.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	193,000	12,000	2%	0.1%
2016	165,000	10,000	1.8%	0.1%
2017	147,000	9,000	1.6%	0.1%
2018	146,000	10,000	1.6%	0.1%
2019	149,000	11,000	1.6%	0.1%

Percent change between 2018 and 2019
NaN%

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

○   Yes

◉   No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

○   Yes

●   No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

N/A

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

○   Yes

●   No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

◉ Yes

> 2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?
>
> Data is not available at this time, as DHCS is in the process of validating data submitted by CBO project partners. Once validated, the data reporting will show the impact of the outreach efforts to reach uninsured, low-income children.

○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

Local, community-based organizations (CBOs) use various methods to reach uninsured, low-income children. The methods include embedding Health Enrollment Navigators at homeless shelters, emergency rooms, clinics, and other critical places where families seek any type of government assistance. In addition, some CBOs work closely with school districts to provide flyers and pamphlets regarding Medi-Cal enrollment to be disbursed with school-related information to all students. Other CBOs use language specific media such as radio and television advertisements, as well as social media campaigns and printed materials placed in strategic locations.

4. Is there anything else you'd like to add about your outreach efforts?

Not at this time.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

○   Yes

◉   No

○   N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

○   Yes

◉   No

○   N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

0   %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

○   Yes

◉   No

○   N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

For Question 3, above, California does not track this information.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?
This question should only be answered in respect to Separate CHIP.

◉ Yes

> 1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

> | %|
> |---|

> 1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

> | %|
> |---|

○ No

○ N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

◉ Yes

◯ No

3. Do you send renewal reminder notices to families?

◉ Yes

> 3a. How many notices do you send to families before disenrolling a child from the program?

> | |
> | --- |
> | If eligibility cannot be redetermined via an ex parte review, California sends a pre-populated renewal form to the individual providing at least 60 days for response prior to disenrollment. |

> 3b. How many days before the end of the eligibility period did you send reminder notices to families?

> | |
> | --- |
> | At least 30 days prior to the renewal due date, there is county contact regarding the renewal form or missing information requirements. This contact is made by the subscriber's preferred language and method (phone, mail, etc.) If information is not received, a notice of action (NOA) to discontinue must be sent ten days prior to the end of renewal due month. If it is not possible to issue a NOA that allows the ten day notice at the end of the renewal month, the individual will be eligible the following month. |

◯ No

4. What else have you done to simplify the eligibility renewal process for families?

California instituted many provisions as part of the ACA to simplify the renewal process including conducting an ex parte review of electronic data sources and current case information to complete the renewal without anything needed from the beneficiary and sending a pre-populated renewal forms in threshold languages when additional information is required. Other improvements California has implemented include resetting the annual renewal date at change of circumstance redeterminations made between annual renewals, partnering with community based organizations to assist beneficiaries with renewal paperwork as needed, use of self-attestations when documentary proof is not available, and allowing telephonic and electronic signature for the renewal form.

5. Which retention strategies have you found to be most effective?

California providing premium relief to individuals affected by natural disasters and authorizing county flexibilities with renewals during these emergencies, has been effective in retaining subscribers. California has implemented several strategies to continue coverage during the COVID-19 Public Health Emergency (PHE). California instructed counties to delay processing of annual renewals and reported changes in circumstances and to delay any discontinuance or negative actions as a result of an annual renewal or change in circumstance. Additionally, California has allowed flexibilities for verifying needed case information such as allowing self-attestation and accepting written affidavits telephonically.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

California has not evaluated the effectiveness of any strategies at this time.

7. Is there anything else you'd like to add that wasn't already covered?

Question 1a, above, is left blank. California cannot provide the percentage of children presumptively enrolled (PE) in CHIP as California does not segregate CHIP applicants from other applications. Question 1b, above, is left blank. California cannot provide the percentage of children presumptively enrolled (PE) in CHIP, as California does not segregate CHIP applications from other applications.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2020?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

> 3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4. How many applicants were denied CHIP coverage for other reasons?

5. Did you have any limitations in collecting this data?

Questions 1-5, above, are left blank. In California, Title XXI applicants are not segregated from other applicants, due to the ACA requirement for a SSApp in the state. Because of this, and the level of granularity for this data set, denial data is not provided.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	
Denied for procedural reasons	
Denied for eligibility reasons	
Denials for other reasons	

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2020?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in CHIP after redetermination?

[   ]

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

[   ]

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

[   ]

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

[   ]

4c. How many children were disenrolled for other reasons?

[   ]

5. Did you have any limitations in collecting this data?

California's redetermination reporting data does not differentiate between Medicaid and CHIP renewal processing, and as such, has left the data set blank.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew

in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2020?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in Medicaid after redetermination?

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

> 4a. How many children were disenrolled for procedural reasons?
> This could be due to an incomplete application, missing documentation, or a missing enrollment fee.
>
> 4b. How many children were disenrolled for eligibility reasons?
> This could be due to an income that was too high and/or eligibility in CHIP instead.
>
> 4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting this data?

California's redetermination reporting data does not differentiate between Medicaid and CHIP renewal processing, and as such, has left the data set blank.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or

younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○   Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

◉   Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

⦿ Yes

○ No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
2429	28386	30193	8570

July - September 2020 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1607	20852	23479	6588

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
14	117	123	38

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	92	95	32

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
808	7417	6591	1944

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
525	5818	4590	1146

9. Is there anything else you'd like to add about your data?

N/A

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

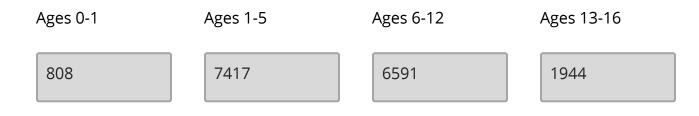| Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

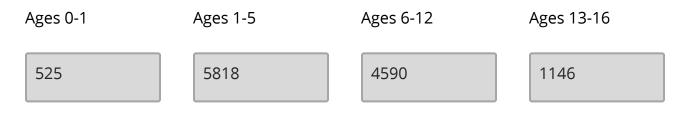Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

[   ]   [   ]   [   ]   [   ]

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

[   ]   [   ]   [   ]   [   ]

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

[   ]   [   ]   [   ]   [   ]

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○   Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

◉   Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
57601	18438	20866	8954

July - September 2020 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
44169	10435	11949	5220

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

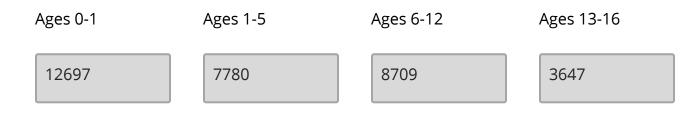| Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
735	223	208	87

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
18	18	47	13

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
12697	7780	8709	3647

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
483	903	1507	652

9. Is there anything else you'd like to add about your data?

N/A

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in Medicaid 12 months later? Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
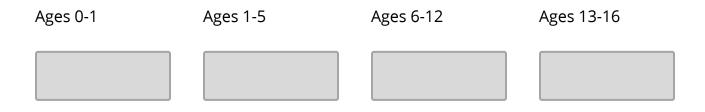Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in Medicaid 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?
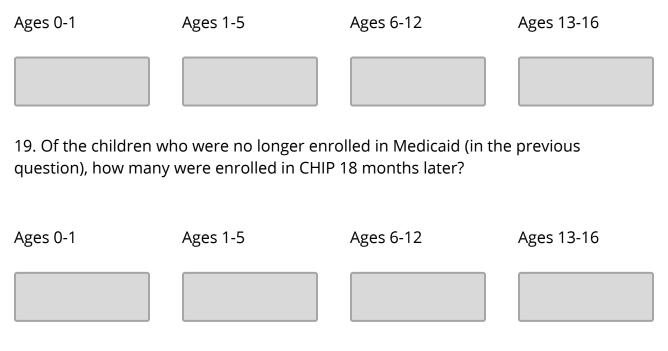
Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1   Ages 1-5   Ages 6-12   Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

(●) Yes

( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- ○ Families ("the shoebox method")

- ○ Health plans

- ○ States

- ● Third party administrator

- ○ Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

> While the State's premium processing vendor tracks the 5% cap amount to ensure that no family reaches the limit, as we indicated above it is not possible for families to reach the 5% cap. Therefore, the 5% cap is never exceeded and there is never a need to notify providers about non-enforceable cost sharing. • The 5% ceiling of a three child household with the Annual Income at 261% of the FPL is $3,210. For a CCHIP family with three children, the annual premium cost would be $756, well below the 5% ceiling of $3,210. • MCAP has a lower income range for eligibility at 208% of the FPL. MCAP premiums are set as 1.5% of the families Annual Income. For a three person family that would be in the amount of $767, well below the 5% Ceiling of $2,558.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

> The state's premium processing vendor tracks the 5% cap and no families have been identified.

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

○ Yes

◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

○ Yes

◉ No

8. Is there anything else you'd like to add that wasn't already covered?

> N/A

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

○ Yes

⦿ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

⦿ Yes

○ No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

⦿ Yes

○ No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

◉ Yes

○ No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

> Audits & Investigations (A&I) Division works collaboratively with the DHCS Provider Enrollment Division towards fraud prevention via a comprehensive and analytics-based approach to screening and eliminating problem providers from the program. Activities include enhanced prescreening activities, provider education and the investigation of suspect providers as early as possible to minimize any widespread damage to the program. A&I also performs data mining and data analytics for case development and to detect fraudulent schemes, suspicious providers, and the identification of new fraud schemes. A&I staff conduct on-site field reviews and audits of suspicious providers, which may lead to overpayment recoveries, administrative sanctions, utilization controls, or referrals to A&I's Investigations branch for a preliminary criminal investigation, or directly to the Medicaid Fraud Control Unit (MFCU) when sufficient evidence has been gathered to establish a credible allegation of fraud, waste or abuse. Besides regular referrals to the MFCU, A&I routes criminal fraud referrals to the FBI, and the U.S. Attorney. A&I staff work closely with these entities and also have a presence on various local and national task forces.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

○ Yes

    5a. What safeguards and procedures do the Managed Care plans have in place?

    Managed care plans have compliance plans, policies, and procedures for the prevention, investigation, and referral of fraud and abuse cases. These provisions are outlined in the plans' DHCS approved contracts under Exhibit E, Attachment 2 Program Terms and Conditions, Fraud and Abuse.

○ No

○ N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2020?

7. How many cases have been found in favor of the beneficiary in FFY 2020?

8. How many cases related to provider credentialing were investigated in FFY 2020?

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

10. How many cases related to provider billing were investigated in FFY 2020?

113

11. How many cases were referred to appropriate law enforcement officials in FFY 2020?

87

12. How many cases related to beneficiary eligibility were investigated in FFY 2020?

619

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

420

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

○   CHIP only

◉   Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

◉   Yes

        15a. How do you provide oversight of the contractors?

DHCS relies on the use of contractors within managed care and dental fee for service.

○   No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

⦿ Yes

> 16a. What specifically are the contractors responsible for in terms of oversight?
>
> The medical managed care plans' responsibilities are outlined in the plans' approved contracts under Exhibit E, Attachment 2 Program Terms and Conditions, Fraud and Abuse. The mental health managed care plans' responsibilities are outlined in the plans' approved contracts under Exhibit A. The managed care dental plans' responsibilities are outlined in the plans' approved contracts under Exhibit E.

◯ No

17. Is there anything else you'd like to add that wasn't already covered?

Questions 6-9, above, are left blank. California does not collect fair hearing appeals data regarding separate CHIP programs. California plans to work towards the ability to capture separate CHIP appeals data. DHCS may be able to track and report on this information for the 2021 CARTS report.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).
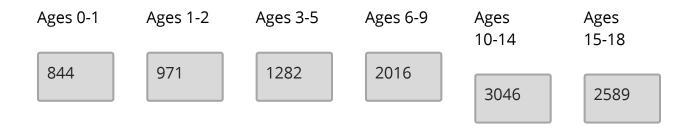
Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5" group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

◉ Yes

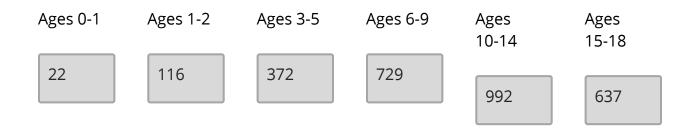◯ No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
844	971	1282	2016	3046	2589

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

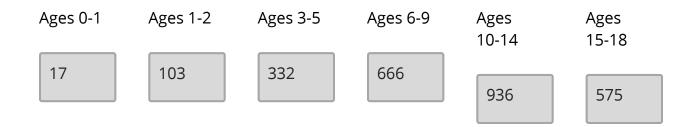| Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
22	116	372	729	992	637

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?

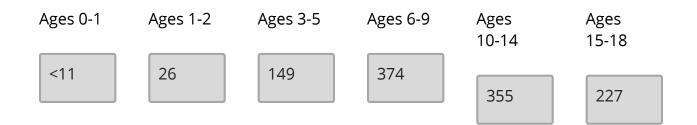| Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
17	103	332	666	936	575

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	26	149	374	355	227

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

133

Sealant codes and definitions

The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

○ Yes

◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

> Not at this time.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

[Browse...]

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and

customer satisfaction.

1. Did you collect the CAHPS survey?

⦿ Yes

   1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?

   ○ Yes

   ⦿ No

○ No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.
This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

2. Which CHIP population did you survey?

○   Medicaid Expansion CHIP

○   Separate CHIP

◉   Both Separate CHIP and Medicaid Expansion CHIP

○   Other

3. Which version of the CAHPS survey did you use?

○   CAHPS 5.0

◉   CAHPS 5.0H

○   Other

4. Which supplemental item sets did you include in your survey?
Select all that apply.

☐   None

☑   Children with Chronic Conditions

☐   Other

5. Which administrative protocol did you use to administer the survey?
Select all that apply.

☑ NCQA HEDIS CAHPS 5.0H

☐ HRQ CAHPS

☐ Other

6. Is there anything else you'd like to add about your CAHPS survey results?

See attachment: 2020 CHIP CAHPS Survey Results

Part 3: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

○   Yes

○   No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

[   ]

2. Are you currently operating the HSI program, or plan to in the future?

○　　Yes

○　　No

3. Which populations does the HSI program serve?

[   ]

4. How many children do you estimate are being served by the HSI program?

[   ]

5. How many children in the HSI program are below your state's FPL threshold?

[   ]

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

[   ]

7. What outcomes have you found when measuring the impact?

[   ]

8. Is there anything else you'd like to add about this HSI program?

[   ]

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

[Browse...   ]

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

> Through its culture of care, California's effort to continually reduce the number of uninsured children is maintained as the state's primary goal. This includes goals of increasing awareness for low-income families about the availability of comprehensive low or no cost health coverage for children and the importance of timely and ongoing care for children. This can be achieved through awareness and education of the importance of ongoing care for children.

2. What type of goal is it?

- ◯ New goal

- ⦿ Continuing goal

- ◯ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

The numerator is defined as the number of uninsured children in the state in 2018 minus the number of uninsured children in the state in 2019.

4. Numerator (total number)

34000

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

The denominator is defined as the number of uninsured children in the state in 2018.
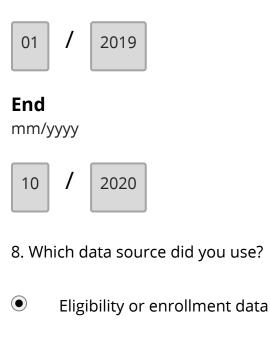
6. Denominator (total number)

299000

Computed: 11.37%

7. What is the date range of your data?

Start
mm/yyyy

| 01 | / | 2019 |

End
mm/yyyy

| 10 | / | 2020 |

8. Which data source did you use?

◉ Eligibility or enrollment data

◯ Survey data

◯ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

> The number of uninsured children was maintained in 2019 at 299,000. While there is a nationwide trend in an increase of uninsured children, California maintained its numbers. California is still identified as having a significantly lower rate of uninsured children as compared to the national average of uninsured rates among children.

10. What are you doing to continually make progress towards your goal?

California continues to take steps to implement the "Infant Initiative" into CalHEERS. The "Infant Initiative" will allow mothers covered under the CHIP higher income unborn option to enroll their newborns into MCAIP via the online portal, as well as allow CalHEERS to retain enrollment data for this program.

11. Anything else you'd like to tell us about this goal?

California will continue efforts to reduce the number of uninsured children in California up through 2022.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?
Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Maintain HEDIS® at or above the NCQA 50th National Medicaid percentile.

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

> Maintain performance at or above National Committee for Quality Assurance (NCQA) National Medicaid 50th percentile for the HEDIS measure Children & Adolescents' Access to Primary Care Practitioners -12 -24 Months.

2. What type of goal is it?

- ◉ New goal

- ○ Continuing goal

- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

> Children 12-24 Months: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year.

4. Numerator (total number)

158268

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

The eligible population: Children 12-24 Months as of December 31 of the measurement year. Includes all children who are at least 12 months old but younger than 25 months old during the measurement year.

6. Denominator (total number)

168922

Computed: 93.69%

7. What is the date range of your data?

Start
mm/yyyy

01 / 2019

End
mm/yyyy

12 / 2019

8. Which data source did you use?

○   Eligibility or enrollment data

○   Survey data

●   Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

> The goal is a new goal. In the measurement year of 2020, DHCS increased its requirement for MCPs on minimum performance level from the 25th percentile to 50th percentile of National Medicaid Benchmarks.

10. What are you doing to continually make progress towards your goal?

> Measurement year 2020 is the first year of the new goal.

11. Anything else you'd like to tell us about this goal?

> DHCS will keep the goal in future years. DHCS will maintain the same goal.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?
Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Maintain HEDIS® performance at or above the NCQA's 50th National Medicaid percentile

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Maintain performance at or above the NCQA's 50th National Medicaid percentile for the HEDIS® measure immunizations Status - Combination 10.

2. What type of goal is it?

- ⦿ New goal

- ◯ Continuing goal

- ◯ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Including CHIP and Medicaid managed care population.

4. Numerator (total number)

70571

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Children 2 years of age. Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

184147

Computed: 38.32%
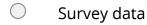
7. What is the date range of your data?

Start
mm/yyyy

| 01 | / | 2019 |

End
mm/yyyy

| 12 | / | 2019 |

8. Which data source did you use?

○ Eligibility or enrollment data

○ Survey data

⦿ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

> The goal is a new goal. In the measurement year of 2020, DHCS switched from CIS-combination 3 to CIS-combination 10, and also increased its requirement for MCPs on minimum performance level from the 25th percentile to 50th percentile of National Medicaid Benchmarks.

10. What are you doing to continually make progress towards your goal?

> Measurement year 2020 is the first year of the new goal.

11. Anything else you'd like to tell us about this goal?

> DHCS will keep the goal in future years. DHCS will maintain the same goal.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?
Optional

1. What is the next objective listed in your CHIP State Plan?

Ensure the participation of community-based organizations (CBOs) in outreach and education activities

1. Briefly describe your goal for this objective.

DHCS's goal is to ensure that there is coverage in all 58 counties to reach as many uninsured, low-income children as possible. DHCS has focused its CBO participation efforts in counties where local agencies are unable to serve their residents, as well as in counties that have expressed a desire to partner with one or more CBOs, to ensure that all this population is best served with as much outreach and enrollment as possible. DHCS recognizes that local CBOs are integral to the success of this project, as they work and live in the areas they serve. We have made multiple efforts to notify CBOs of available funding and areas that are not being served by their local county agency, and notified project partners and interested CBOs that the application/award process will remain open until such time that all funding is allocated.

2. What type of goal is it?

○   New goal

◉   Continuing goal

○   Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of children under the age of 18 recently enrolled into Medi-Cal.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

The total number of potentially eligible children under the age of 18 by county.
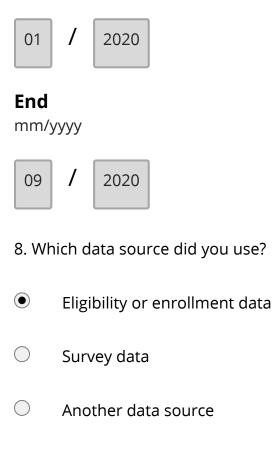
6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start
mm/yyyy

| 01 | / | 2020 |

End
mm/yyyy

| 09 | / | 2020 |

8. Which data source did you use?

- ⦿ Eligibility or enrollment data

- ○ Survey data

- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

At this time, this is unquantifiable. For question #4 above: At this time, the numerator is unquantifiable due to the fact the data is in the validation process. For question #6 above: At this time, the denominator is unquantifiable due to the fact the data is in the validation process.

10. What are you doing to continually make progress towards your goal?

Monthly meetings with CBO partners, as well as one-on-one check-ins between the CBO and their assigned DHCS staff. Quarterly data and progress reports are required of each CBO and county partner. Ad-hoc sessions are conducted to share best practices.

11. Anything else you'd like to tell us about this goal?

There are plans to maintain this goal over the next three years.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?
Optional

1. What is the next objective listed in your CHIP State Plan?

Encourage the inclusion of traditional and safety net providers in health plan networks.

1. Briefly describe your goal for this objective.

The goals related to this objective include increases in the number of children enrolled in health coverage who have access to a provider located within their zip code. Further, this objective looks to increase the number of children who have access to traditional and safety net providers as defined by Health Resources and Services Administration's Federally Qualified Health Center Look-Alike Program.

2. What type of goal is it?

○ New goal

◉ Continuing goal

○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The total number of children eligible enrolled in coverage who have access to a provider within their zip code of residence.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

The Denominator being measure to calculate a ratio would be the number of children enrolled in coverage who do not have access to a provider within their zip code of residence.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start
mm/yyyy

| / |

End
mm/yyyy

| / |

8. Which data source did you use?

○ Eligibility or enrollment data *(selected)*

○ Survey data

○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

> This is currently a new goal, and the primary focus has been to reduce the number of uninsured children in the state.

10. What are you doing to continually make progress towards your goal?

>

11. Anything else you'd like to tell us about this goal?

> This is currently a new goal; however, it is proposed to require participating plans to report annually on the number of subscribers selecting traditional and safety net providers. DHCS has plans to keep this goal for future years.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

None at this time.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

None at this time.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

None at this time.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 2,667,288,125	$ 2,540,049,031	$ 2,499,029,459

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 1,207,877,605	$ 2,097,154,725	$ 2,166,141,625

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	$ 0	$ 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 67,637,149	$ 66,347,407	$ 64,270,000

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2020	FFY 2021	FFY 2022
Managed Care	2667288125	2540049031	2499029459
Fee for Service	1207877605	2097154725	2166141625
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	67637149	66347407	64270000
Total benefit costs	3942802879	4703551163	4729441084

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?
This includes wages, salaries, and other employee costs.

2020

$ 11,826,135

2021

$ 21,916,238

2022

$ 20,861,313

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	$ 0	$ 0

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	$ 0	$ 0

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 46,509,127	$ 86,190,890	$ 82,042,142

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	$ 0	$ 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	$ 0	$ 0

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	$ 0	$ 0

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2020	FFY 2021	FFY 2022
Personnel	11826135	21916238	20861313
General administration	0	0	0
Contractors and brokers	0	0	0
Claims processing	46509127	86190890	82042142
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	0	0	0
Other administrative costs	0	0	0
Total administrative costs	58335262	108107128	102903455
10% administrative cap	423058731.22	507872927.67	511211231.56

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2020	FFY 2021	FFY 2022
Total program costs	4001138141	4811658291	4832344539
eFMAP	76.50	65	65
Federal share	3060870677.87	3127577889.15	3141023950.35
State share	940267463.13	1684080401.85	1691320588.65

8. What were your state funding sources in FFY 2020?
Select all that apply.

- ☑ State appropriations

- ☑ County/local funds

- ☐ Employer contributions

- ☐ Foundation grants

- ☐ Private donations

- ☑ Tobacco settlement

- ☑ Other

  8a. What other type of funding did you receive?

  Healthcare Treatment Fund Prop 56

9. Did you experience a shortfall in federal CHIP funds this year?

- ○ Yes

- ◉ No

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1. How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
1652184	1777420	1696547

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
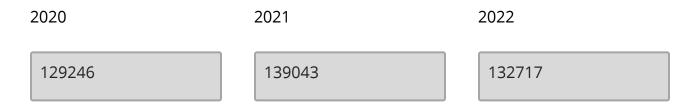Round to the nearest whole number.

2020	2021	2022
$ 180	$ 159	$ 164

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost	180	159	164

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1. How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

129246

2021

139043

2022

132717

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020

$ 1,340

2021

$ 2,162

2022

$ 2,340

	FFY 2020	FFY 2021	FFY 2022
PMPM cost	1340	2162	2340

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

See attached: Federal and State Shares Expenditures Summary Table

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

California's political and fiscal environment has been supportive of efforts to maintain health care coverage for low-income, uninsured children under the Affordable Care Act (ACA). This environment has also allowed the state to support health coverage for low-income, uninsured children. Additionally, the increase in federal financial participation for CHIP in October 2015 helped strengthen those efforts to reach uninsured children within the state.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

The COVID-19 public health emergency (PHE) was the greatest challenge our CHIP program faced in FFY 2020, due to the impact on delayed preventive services for children, remote learning, increased stress and mental health needs of parents and children, and the disruption of the state's health care delivery system, including individual providers, clinics, hospitals, and managed care plans. DHCS has worked closely with our program partners and state and federal officials to address key challenges to ensure Medicaid and CHIP children continue to have access to all necessary care, including COVID-19 testing and care. In FFY 2020, California also continued its ongoing efforts to increase children's preventive services utilization, including immunizations, and children's dental preventative care.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

For the reporting period of October 2019 through September 2020, DHCS accomplishments include: In response to the COVID-19 pandemic, DHCS implemented more than 50 programmatic flexibilities for providers, beneficiaries, and health plans to address the delivery system disruption and health care needs of beneficiaries. These flexibilities impact Medi-Cal eligibility, health care service delivery (e.g., telehealth), provider reimbursement, and many other aspects of the program. DHCS covers both COVID-19 viral and serologic (antibody) tests, at no-cost to Medi-Cal beneficiaries. Further, DHCS has implemented the COVID-19 Uninsured Group Program, which covers free COVID-19 diagnostic testing and treatment services and is available to uninsured individuals determined eligible for up to 12 months or the end of the public health emergency, whichever comes first. In March 2020, DHCS launched the Preventive Care Outreach Project to increase utilization of preventive services by all eligible Medi-Cal beneficiaries under age 21. Phase 1 of this outreach effort began in March 2020 with a targeted outreach letter being mailed by DHCS to approximately five million beneficiaries. This notice informs beneficiaries under age 21 with full-scope Medi-Cal eligibility about the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and how to access services. A targeted call campaign to these beneficiaries about the EPSDT benefit and how to access services was delayed due to concerns surrounding COVID-19. In 2016 California voters approved the California Healthcare, Research and Prevention Tobacco Tax Act (also known as "Proposition 56"). This Act authorized supplemental payments to providers, including those that serve children. Highlights of the funding in the reporting period FFY 2020 include: • Extension of supplemental payments for physicians, dentists, women's health services, non-emergency medical transportation (NEMT) , intermediate care facilities for the developmentally disabled (ICF/DD) providers, freestanding pediatric subacute (FS/PSA) facilities, and select 1915(c) Home and Community-Based Services (HCBS) Waiver services, including many providers that serve children. In addition, there are Proposition 56-funded ongoing rate increases for home health agencies and pediatric day health care programs. • Effective January 1, 2020, Proposition 56 funding is being used to support developmental and trauma screenings for children ages 0-21. These screenings are being billed and reimbursed in both the managed care and fee-for-service (FFS) delivery systems. These supplemental payments are in addition to the amounts paid generally for

the office visit in FFS scenarios or capitation paid by managed care plans. • Further, DHCS continues to implement a Value-Based Payment Program (VBP) through the Medi-Cal managed care plans. VBP provides incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. The program also incentivizes improved data quality and completeness. These risk-based incentive programs are targeted at physicians that meet specific achievement on metrics targeting areas such as behavioral health integration, prenatal/post- partum care and chronic disease management. Additionally, due to the unfortunate wildfires from 2017 through 2020 that displaced so many families, California has maintained SPA authority to waive premiums and certain eligibility verification requirements on a temporary basis to assist families that were affected by the natural disasters. In October 2019, DHCS successfully transitioned Population 1 (CCHIP) into the Medi-Cal Managed Care Delivery System, providing this population all the benefits provided to Medi-Cal subscribers/beneficiaries. This policy will help improve operational and administrative efficiencies for program administration and service delivery for Population 1. California continued to identify delivery system changes to the California Children's Services (CCS) program, to improve quality and coordination of care for Children and Youth with Special Health Care Needs. The goal is an integrated, organized delivery system built on the existing managed care model, to address all of the health care needs of children with CCS conditions through improved care coordination. In September 2020, DHCS updated its internal communication process, creating three new email inboxes to reduce confusion related to the submission of inquiries to DHCS from county CCS offices. California continued the Dental Transformation Initiative (DTI), to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. As of September 2020, 2,999 Medi-Cal dental providers have opted to participate in Domain 2. The goals of Domain 2 are to assess Medi-Cal children ages six (6) and under for caries risk and to manage the disease of caries using preventive services and non-invasive treatment approaches instead of more invasive and costly restorative procedures. Furthermore, DHCS has helped promote teledentristy as an alternative modality for the provision of select dental services. California continued to focus on the need to increase the percentage of children receiving the following vaccinations: four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B; one varicella-zoster virus (chicken pox or VZV); and four

pneumococcal conjugate vaccinations on or before the child's second birthday. In this reporting period California has demonstrated compliance with the Medicaid and CHIP Managed Care Final Rule (2016 Final Rule) in the delivery of CHIP services and benefits covered under the state's separate child health plan. In June 2020 DHCS launched the CalAIM Foster Care Model of Care Workgroup to create a long-term plan for how children and youth in foster care receive health care services (physical health, mental health, substance use disorder treatment, social services, and oral health) and as an opportunity for stakeholders to provide feedback on ways to improve the current system of care for children and youth in foster care. The workgroup also will determine whether or not a new system of care should be developed.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

In FFY 2021 DHCS will continue efforts to respond to the COVID-19 pandemic. Given the unpreceded nature of the COVID-19 PHE, DHCS will continue to seek federal approval related to program flexibilities. California continues efforts to reduce health disparities in the Medi-Cal program, to help achieve high quality health care for all beneficiaries, including children and families. As part of those efforts, DHCS publishes an annual report on health disparities in Medi-Cal managed care, which includes differences in quality measures for children by race and ethnicity. In FFY 2020 DHCS released a Request for Information to prepare for reprocurement of Medi-Cal managed care plans, and identified reducing health disparities as a primary goal for managed care plan reprocurement. DHCS also regularly publishes a variety of data on the Medi-Cal program, and includes a number of demographic identifiers in that data. In FFY 2021 DHCS will develop a performance and outcomes system for children and youth in Medi-Cal mental health services in an effort to improve health outcomes. Further, California will continue to provide incentive payments in FFY 2021 targeted at providers, public hospital systems, and managed care and mental health plans to maximize health care and payment reform, including efforts to address health disparities. Additionally, as part of the Adverse Childhood Experiences (ACEs) Aware initiative, eligible Medi-Cal providers will continue to receive training, clinical protocols, and payment for conducting qualifying ACEs screenings for children and adults (through age 64) with full-scope Medi-Cal. Finally, DHCS will relaunch the California Advancing and Innovating Medi-Cal (CalAIM) initiative, to improve the entire continuum of care from birth to end of life. California continues to expand and extend efforts to enroll hard-to-reach people through the Medi-Cal Health Enrollment Navigators Project. Due to the community health impacts of COVID-19, navigator services are now critically important. Project partners have implemented innovative and creative approaches to contact and enroll the eligible hard-to-reach populations in their local communities. Starting in reporting year 2020, DHCS adopted the CMS Child Core Set as the basis for the performance measures that all Medi-Cal MCPs are required to report on. While DHCS' prior set of required managed care performance metrics had numerous measures devoted to access and quality of care for children, DHCS believes that adopting the CMS Child Core Set will provide a more robust measurement of access and quality of care for children and provide a better lever for driving improvement. Finally, California

continues to use funding from Proposition 56 to provide supplemental payments to providers, including those that serve children. California also continues working with CMS, seeking SPA approval to demonstrate parity between mental health services and medical services as it relates to CHIP.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

California has nothing further to add.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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